

requested by SSA to support the application. (SSA will specify in the initial determination the conditions of entitlement that the applicant failed to establish by not submitting the requested evidence);

(3) A denial of a request for withdrawal of an application for hospital or supplementary medical insurance;

(4) A denial of a request for cancellation of a “request for withdrawal”; and

(5) A determination as to whether an individual, previously determined to be entitled to hospital or supplementary medical insurance, is no longer entitled to such benefits, including a determination based on nonpayment of premiums.

(b) *Requests for payment by or on behalf of individuals.* An initial determination with respect to an individual includes any determination made on the basis of a request for payment by or on behalf of the individual under part A of Medicare, including a determination with respect to:

(1) The coverage of items and services furnished;

(2) The amount of an applicable deductible;

(3) The application of the coinsurance feature;

(4) The number of days of inpatient hospital benefits utilized during a spell of illness or for purposes of the inpatient psychiatric hospital 190-day lifetime maximum;

(5) The number of days of the 60-day lifetime reserve utilized for inpatient hospital coverage;

(6) The number of days of posthospital extended care benefits utilized;

(7) The number of home health visits utilized;

(8) The physician certification requirement;

(9) The request for payment requirement;

(10) The beginning and ending of a spell of illness, including a determination made under the presumptions established under § 409.60(c)(2) of this chapter, as specified in § 409.60(c)(4) of this chapter.

(11) The medical necessity of services (See parts 466 and 473 of this chapter for provisions pertaining to initial and

reconsidered determinations made by a QIO);

(12) When services are excluded from coverage as custodial care (§ 411.15(g)) or as not reasonable and necessary (§ 411.15(k)), whether the individual or the provider of services who furnished the services, or both, knew or could reasonably have been expected to know that the services were excluded from coverage (see § 411.402);

(13) Any other issues having a present or potential effect on the amount of benefits to be paid under part A of Medicare, including a determination as to whether there has been an overpayment or underpayment of benefits paid under part A, and if so, the amount thereof; and

(14) Whether a waiver of adjustment or recovery under sections 1870 (b) and (c) of the Act is appropriate when an overpayment of hospital insurance benefits or supplementary medical insurance benefits (including a payment under section 1814(e) of the Act) has been made with respect to an individual.

(c) *Initial determination with respect to a provider of services.* An initial determination with respect to a provider of services shall be a determination made on the basis of a request for payment filed by the provider under part A of Medicare on behalf of an individual who was furnished items or services by the provider, but only if the determination involves the following:

(1) A finding by the intermediary that such items or services are not covered by reason of § 411.15(g) or § 411.15(k); and

(2) A finding by the intermediary that either such individual or such provider of services, or both, knew or could reasonably have been expected to know that such items or services were excluded from coverage under the program.

[55 FR 11020, Mar. 26, 1990]

§ 405.705 Actions which are not initial determinations.

An initial determination under Part A of Medicare does not include determinations relating to:

(a) The reasonable cost of items or services furnished under Part A of Medicare;

(b) Whether an institution or agency meets the conditions for participation in the program;

(c) Whether an individual is qualified for use of the expedited appeals process as provided in § 405.718;

(d) An action regarding compromise of a claim arising under the Medicare program, or termination or suspension of collection action on such a claim under the Federal Claims Collection Act of 1966 (31 U.S.C. 3711). See 20 CFR 404.515 for overpayment claims against an individual, § 405.376 for overpayment claims against a provider, physician or other supplier, and § 408.110 for claims concerning unpaid Medicare premiums;

(e) The transfer or discharge of residents of skilled nursing facilities in accordance with § 483.12 of this chapter; or

(f) The preadmission screening and annual resident review processes required by part 483 subparts C and E of this chapter.

[45 FR 73932, Nov. 7, 1980; 46 FR 24565, May 1, 1981, as amended at 52 FR 22454, June 12, 1987; 52 FR 48123, Dec. 18, 1987; 57 FR 56504, Nov. 30, 1992; 61 FR 63749, Dec. 2, 1996]

§ 405.706 Decisions of utilization review committees.

(a) *General rule.* A decision of a utilization review committee is a medical determination by a staff committee of the provider or a group similarly composed and does not constitute a determination by the Secretary within the meaning of section 1869 of the Act. The decision of a utilization review committee may be considered by CMS along with other pertinent medical evidence in determining whether or not an individual has the right to have payment made under Part A of title XVIII.

(b) *Applicability under the prospective payment system.* CMS may consider utilization review committee decisions related to inpatient hospital services paid for under the prospective payment system (see part 412 of this chapter) only as those decisions concern:

(1) The appropriateness of admissions resulting in payments under subparts D, E and G of part 412 of this chapter.

(2) The covered days of care involved in determinations of outlier payments under § 412.80(a)(1)(i) of this chapter; and

(3) The necessity of professional services furnished in high cost outliers under § 412.80(a)(1)(ii) of this chapter.

[48 FR 39831, Sept. 1, 1983]

§ 405.708 Effect of initial determination.

(a) The initial determination under § 405.704 (a) or (b) shall be binding upon the individual on whose behalf payment under part A has been requested or, if such individual is deceased, upon the representative of such individual's estate, unless it is reconsidered in accordance with §§ 405.710 through 405.717 or revised in accordance with § 405.750. Such individual (or the representative of such individual's estate if the individual is deceased) shall be the party to such initial determination.

(b) The initial determination under § 405.704(c) shall be binding upon the provider of services unless it is reconsidered in accordance with §§ 405.710 through 405.717 or revised in accordance with § 405.750. Such provider of services shall be the party to such initial determination.

[55 FR 11021, Mar. 26, 1990, as amended at 62 FR 25855, May 12, 1997]

§ 405.710 Right to reconsideration.

(a) An individual who is a party to an initial determination, as specified in § 405.704 (a) and (b), (or if such individual is deceased, the representative of such individual's estate) and who is dissatisfied with the initial determination may request a reconsideration of such determination in accordance with § 405.711 regardless of the amount in controversy.

(b) A provider of services who is a party to an initial determination (as specified in § 405.704(c)) and who is dissatisfied with such initial determination may request a reconsideration of such determination in accordance with § 405.711, regardless of the amount in controversy, but only if the individual on whose behalf the request for payment was made has indicated in writing that he does not intend to request reconsideration of the intermediary's initial determination on such request for payment, or if the intermediary has made a finding (see § 405.704(c)) that such individual did not know or could